2016-2442

PRINTED: 12/29/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS This State Hospital Licensing Survey was conducted on 12/12/2016-12/14/2016 by Lisa Mahoney MPH, PHA and Cathy Strauss, BSN, RN. The Washington Fire Protection Bureau conducted the fire life safety inspection on 12/13/2014. ASE# QJR011 RECEIVED JAN 27 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 1/16/2017. 4. Return the ORIGINAL REPORT with the required signatures.	
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing:	L 690	RECEIVED JAN 17 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 1/13/17

STATE FORM 021199 QJR011 If continuation sheet 1 of 9

Plan of Correction received 1-17-2017 CStrauss 1-30-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 1 (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: Based on observation, interview and review of hospital policies and procedures, the hospital failed to ensure staff performed hand hygiene according to hospital policies. Failure to follow infection control practices risks transmitting infections to staff and patients. Findings: 1. The hospital policy titled "Hand hygiene" (Policy #1600.4.4, revised 11/2016) read in part; " 1. Employees are required to wash hands thoroughly: 1.3- before and after each patient contact. 1.4-After contact with potentially contaminated environmental surfaces. " 2. On 12/12/2016 at 2:00 PM, Surveyor #1 observed the Medication Nurse (Staff Member #9) exit the medication room with three pills in a med cup and a bottle of hand sanitizer. The licensed nurse used the door handle with a bare hand, and walked down to the activity room where s/he addressed a patient and confirmed their identity. S/he then offered hand sanitizer to the patient who performed hand hygiene. The staff proceeded to deliver medications to the patient, but failed to perform hand hygiene prior to or after the medication administration. 3. On 12/13/2016 at 1:30 PM, Surveyor #1 observed the medication nurse (Staff Member #2) in the medication room. After performing hand hygiene the med nurse proceeded to remove a	L 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 2 patient's medication from the Pyxis and placed into a med cup. The nurse used the door handle to exit the med room door and attempted to locate the patient. The nurse did not find the patient in the activity room, nor in the patient's room. The nurse then exited the security door to the stairwell and walked down to the first floor. The patient was located eating in the lunchroom. There was no hand sanitizer readily available.	L 690		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to perform electrical safety checks on patient-owned equipment used during the patient's hospital admission. Failure to ensure the safety of all electrical equipment used by patients in the hospital puts patients, staff, and visitors at risk from injury for electrical shock or fire. Findings: 1. The facility's contracted bio-medical engineering service policy titled "Electrical Safety Testing", (effective date: August 15, 2015) stated, "Electrical safety testing will be performed in compliance with NFPA 99 2005 and ANSI/AAMI E60601-1:2005." The scope of the policy indicated the policy affects all equipment inspected, repaired, or managed by the contractor. 2. On 12/12/2016 at 12:20 PM, Surveyor #2	L 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 780	Continued From Page 3 interviewed the Facilities Director (Staff Member #12) about safety checks on patient-owned equipment, following observation of patients' C-Pap (breathing) machines present in patient rooms. The staff member indicated there was no process for engineering staff to evaluate patient-owned items for safety prior to use in the facility.	L 780		
L1220	322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records. (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records; This RULE: is not met as evidenced by: Based on interview and review of the medical records, the hospital failed to develop an effective process to ensure medical records were accurate, complete, and timely, as demonstrated by 7 of 11 charts reviewed (Patients #1, #2, #3, #4, #5, #6, #7). Failure to ensure medical records are accurate and complete risks medical errors, which can misdirect caregivers and / or result in patient harm. Findings: 1. Hospital policy titled "Charting Requirements" (Policy #1000.87, revised 11/2016) read in part "1, A. ...RN Nursing Assessment is initiated on	L1220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1220	Continued From Page 4 admission and completed within 8 hrs. " and " 3- each note needs to be signed, dated and timed ...' 2. On 12/13/2016 at 9:00 AM, Surveyor #1 noted the following variances; a. Patient #7, was admitted 12/8/2016. The nursing assessment was unsigned, undated with no time listed, and remained incomplete as of 12/12/2016. b. Treatment plans were not present in the medical records of Patients #1, #3, #4, and #5 at the time of review. The Charge Nurse (Staff Member #3) reported "someone must have it" that "sometimes they are taken downstairs to an office." c. Restraint and seclusion (R/S) records remained incomplete for Patients #4 and #6. No face to face record was present for Patient #6. Patient response to interventions were unmarked and signatures were untimed on 12/7/2016. The checklist for R/S was incomplete for Patient's #4 and #6. d. There were two provider notations on the Psychiatric Admission Evaluation for Patient #7. One Psychiatrist (Staff Member #8) signed the document but there was no signature authentificating or identifying the second provider. Staff Member #8 reported that the second provider was an extern, and that s/he would instruct them to authenticate their entries. e. Physicians orders were unsigned for Patient #2. 3. On 12/13/2016 at 11:00 AM, Staff Member #6 acknowledged that there were not enough staff available for overseeing the medical record process and confirmed the above findings.	L1220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1415	322-210.3K PROCEDURES-RESTRICTED ACCESS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (k) Restricting access to pharmacy stock of drugs to: (i) Legally authorized pharmacy staff; and (ii) Except for Schedule II drugs, to a registered nurse designated by the hospital when all of the following conditions are met: (A) The pharmacist is absent from the hospital; (B) Drugs are needed in an emergency, and are not available in floor supplies; and (C) The registered nurse, not the pharmacist, is accountable for the registered nurse's actions; This RULE: is not met as evidenced by: Based on interview and review of pharmacy and medication service policies, the hospital failed to follow hospital policy for medication errors. Failure to follow policies and procedures for medication errors risks the well being of the patients, potentially resulting in patient death. Findings: 1. The hospital policy titled "Medication Variances" (Policy #1000.41; Revised 11/2016) read in part; "1.1- In the event that a medication variance occurs or is discovered, it is the responsibility of nursing staff to: 1.1.1- Ensure patient safety by monitoring patient as appropriate, 1.1.2- Notify the physician ...of the nature and severity of the variance as appropriate,	L1415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1415	Continued From Page 6 1.1.3- Notify his/her immediate supervisor, and 1.1.6- Document all of the above in the patient's medical record." 2. On 12/14/2016 at 8:00 AM, Surveyor #1 reviewed the medication variance report for Patient #8. The report stated that on 8/29/2016 at 10:39 PM the patient received a second dose of an antidepressant by the medication nurse (Staff Member #9) The medication nurse reported that he/she had repeated the second dose without first checking the medication orders. 3. On 12/14/2016 at 8:00 AM, Surveyor #1 reviewed Patient #8's medical record and failed to find documentation in the chart that the nurse notified the patient's physician, and his/her supervisor regarding the medication error. There was no evidence that the patient had been monitored for a reaction to the overdose of medication. 4. On 12/14/2016 at 9:30 AM, Surveyor #1 interview with Registered Nurse Manager (RN) (Staff Member #7) confirmed there was no chart documentation of the medication error, only on the variance report. The RN was unaware of any follow up with managers or staff.	L1415		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to comply with chapters 246-215,	L1485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1485	Continued From Page 7 Washington Administrative Code (WAC) for food service. Failure to remain compliant with the Washington State Retail Food Code puts patients, staff and visitors at risk from food-borne illness. Findings: All findings occurred during observation of patient breakfast service on 12/13/2016 between 8:35 and 9:00 AM and during a tour of the contracted Dietary Department on 12/13/2016 between 10:45 and 11:30 AM: 1. At 8:54 AM, Surveyor #2 observed a food service worker (Staff Member #10) as s/he completed removal of soiled dining items from the first breakfast service. Once the staff member finished this task, s/he changed gloves and began to set up for the second breakfast service. The staff member failed to do hand hygiene between glove changes. Reference: Washington State Retail Food Code, WAC 246-215-02310 (5) 2. At 11:15 AM, Surveyor #2 observed cooked turkey breast in the walk-in cooler. The Dietary Manager (Staff Member #11) indicated that cook staff had cooked the turkeys on site and cooled them for later use, using time and temperature controls. Upon review of the cooling logs, the surveyor identified 4 items(beef ribs, 12/10, turkey 12/10, beef ribs, 12/12, potatoes, 12/13) whose internal temperature records indicated were above the maximum allowable temperature of 70 degrees Fahrenheit after 2 hours of cooling, although they were below 41 degrees Fahrenheit within 6 hours of cooling. The log contained no	L1485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1485	Continued From Page 8 documentation of staff member's corrective action to reduce the temperature at the 2-hour deadline. Reference: Washington State Retail Food Code, WAC 246-215-03515 (1) (a)	L1485		